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Supreme Court, U.S.
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No. (1)

In The
Supreme Court of the United States

JAMES A. SHANK, AS TRUSTEE OF THE DEBORAH J. SHANK IRREVOCABLE TRUST, ET AL.,
Petitioners,

v.

ADMINISTRATIVE COMMITTEE OF THE WAL-MART STORES, INC. ASSOCIATES' HEALTH AND WELFARE PLAN,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether it is both "equitable" and "appropriate" to require a catastrophically injured individual to reimburse an ERISA plan when the reimbursement leaves the individual penniless, gives absolute priority to the reimbursement claim without regard to the full extent of injuries and damages sustained, and must be made out of a recovery obtained for damages other than medical expenses.

RULE 14.1(b) STATEMENT

Pursuant to Supreme Court Rule 14.1, Petitioners state that all parties to the proceeding in the court whose judgment is sought to be reviewed are listed as follows:

Defendants - Appellants and Petitioners: James A. Shank, as Trustee of the Deborah J. Shank Irrevocable Trust, Deborah J. Shank, and the Deborah J. Shank Irrevocable Trust.

Plaintiff - Appellee and Respondent: Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan.

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PETITION FOR WRIT OF CERTIORARI

Petitioners James A. Shank, as Trustee of the Deborah J. Shank Irrevocable Trust, Deborah J. Shank, and the Deborah J. Shank Irrevocable Trust (the "Shanks"), respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit.

OPINIONS BELOW

The opinion of the U.S. Court of Appeals for the Eighth Circuit, dated August 31, 2007, is officially reported at 500 F.3d 834, and is reproduced at App. A, 1a - 12a. The U.S. Court of Appeals for the Eighth Circuit's order denying rehearing en banc is reproduced at App. C, 27a - 28a.

The Memorandum Opinion and Order of the U.S. District Court for the Eastern District of Missouri, Southeast Division, dated August 31, 2006, is unofficially reported at 2006 WL 2546797 and is reproduced at App. B, 13a - 26a.

JURISDICTION

The judgment of the U.S. Court of Appeals for the Eighth Circuit sought to be reviewed was entered on August 31, 2007. Petitioners filed a timely motion for rehearing en banc, which was denied on October 29, 2007. This petition is timely under Supreme Court Rule 13.1 because it is being filed within 90 days of the date of denial of rehearing. This Court has jurisdiction to review the judgment of the U.S. Court of Appeals for the Eighth Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions involved are §§ 502(a)(2) and (a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1132(a)(2) and (a)(3). The relevant statutory provisions are reproduced at App. D, 29a - 30a.

STATEMENT OF THE CASE

Deborah J. Shank ("Debbie") was an employee of Wal-Mart Stores, Inc. On May 12, 2000, Debbie was catastrophically injured in a vehicle accident and eventually adjudicated an incompetent.

The Wal-Mart Stores, Inc. Associates' Health and Welfare Plan paid a major portion of Debbie's medical expenses resulting from the accident. Debbie eventually settled her claims against the parties responsible. On August 8, 2002, the United States District Court, Eastern District of Missouri, approved a settlement of Debbie's claims for $700,000.00. After deductions were made for attorneys fees and expenses, the remaining proceeds, approximately $417,477.00, were placed directly into a court-created special needs trust which was established for the sole purpose of providing for Debbie's future needs, with Debbie's husband, James A. Shank, to serve as Trustee.

Three years later, on August 8, 2005, the Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan ("Wal-Mart") filed a complaint against Debbie, the Deborah J. Shank Irrevocable Trust, and James A. Shank, as Trustee of the Deborah J. Shank Irrevocable Trust,

pursuant to § 502(a)(2) and (a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(2) and (a)(3), for "equitable relief and damages" and "for recovery of sums paid by the Wal-Mart Stores, Inc. Associates Health and Welfare Plan for medical services [Debbie] received for injuries she incurred." Wal-Mart alleged that, pursuant to the terms of the Plan, the Plan has a right to be reimbursed from the proceeds of any settlement Debbie received for the injuries she incurred and for which the Plan paid benefits.

Wal-Mart filed its motion for summary judgment on March 15, 2006. The United States District Court for the Eastern District of Missouri entered summary judgment in favor of Wal-Mart on August 31, 2006, and imposed a constructive trust on the settlement proceeds currently held in the Deborah J. Shank Irrevocable Trust in an amount not to exceed $469,216.00.

On August 31, 2007, the Eighth Circuit affirmed the order of the District Court granting Wal-Mart's motion for summary judgment. The Shanks filed a petition for rehearing en banc which was denied on October 29, 2007.

The Shanks petition this Court for a review of the Eighth Circuit's decision that requiring the Shanks to reimburse Wal-Mart in full is "appropriate" under section 502(a)(3).

REASONS FOR GRANTING THE PETITION

This Court has never addressed the important question of whether it is both "equitable" and "appropriate" to require a catastrophically injured individual to reimburse an ERISA plan from a special needs trust established solely for her future medical care, when no judicial determination has been made as to how much, if any, of the settlement recovered by that individual was compensation for past medical expenses that were paid by the ERISA plan. In fact, this Court expressly reserved the question of what is "appropriate" equitable relief under ERISA in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S.Ct. 1869 (2006).

Further, the answer to this question has critical implications for beneficiaries of ERISA plans, for granting reimbursement under such circumstances would permit plan fiduciaries to include provisions that authorize reimbursement of all medical expenses paid on a beneficiary's behalf out of legitimate personal injury settlements, regardless of what these settlement payments were actually intended to compensate. This will have devastating consequences for those victims of catastrophic injury, and will deter victims from seeking any recovery for their injuries from third parties.

This Court should grant certiorari to address the meaning of "appropriate" equitable reimbursement under and to correct the Eighth Circuit's holding that requiring the Shanks to reimburse Wal-Mart in full, thereby depleting Debbie's special needs trust, is "appropriate" under section 502(a)(3).

A. WAL-MART'S PURPORTED CLAIM FOR EQUITABLE RELIEF IS NOT "APPROPRIATE"

Wal-Mart brought the underlying action under section 502(a)(3) of ERISA, which authorizes the fiduciary of an ERISA plan to bring a civil action to enjoin any action which violates the terms of a plan or "to obtain other appropriate equitable relief" to enforce a plan's provisions. 29 U.S.C. § 1132(a)(3).

As this Court has confirmed, § 502(a)(3) requires that any relief awarded be not only "equitable" but "appropriate" as well. *See Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204, 221 n.5 (2002) (citing *Varity Corp. v. Howe,* 516 U.S. 489, 507-15 (1996)). The *Knudson* court made clear that *"Varity Corp.* did not hold . . . that § 502(a)(3) is a catchall provision that authorizes all relief that is consistent with ERISA's purpose and is not explicitly provided elsewhere" because to accept such a position "is to ignore the plain language of the statute, which provides fiduciaries with only equitable relief." *Knudson,* 534 U.S. at 221 n.5.

In *Sereboff v. Mid Atlantic Medical Services, Inc.,* this Court expressly chose not to address the question of what is "appropriate" equitable relief under ERISA because the issue had not been raised in the lower court. *See Sereboff,* 126 S.Ct. at 1877, n.2. In the case at hand, however, the Shanks have asserted from the outset that allowing Wal-Mart full reimbursement does not constitute appropriate equitable relief.

Wal-Mart's purported request for equitable relief against Debbie cannot be reconciled with the actual reimbursement relief requested by Wal-Mart. Because of the limited liability insurance limits of the third-party tortfeasors in the underlying personal injury action, Debbie recovered at settlement only a small portion of her actual economic and non-economic damages. Damages established at the settlement hearing included lost income, pain and suffering, and loss of enjoyment of life. During the hearing the court admitted into evidence a life care plan which estimated Debbie's total *future* economic loss in the amount of $12,520,717.95. No portion of the life care plan was for past medical expenses paid by Wal-Mart. Therefore, giving Wal-Mart the benefit of the doubt by ignoring the non-economic damages for pain and suffering, the total economic loss for Debbie was $12,989,933.95.[1]

Further, no judicial determination has ever been made or sought as to how much, if any, of the settlement recovered by the Shanks was compensation for past medical expenses that were paid by Wal-Mart. It strains credulity to suggest that it is "appropriate" to require Debbie to completely deplete her special needs trust in order to reimburse Wal-Mart and be left with nothing to pay the expenses for her future care.

If this Court finds that the Eighth Circuit properly found reimbursement to be equitable in this action, the

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[1] It is undisputed that Wal-Mart paid Debbie's medical expenses in the amount of $469,216.00. This amount, added to the amount for Debbie's future economic losses, equals $12,989,933.95.

Shanks respectfully suggest that full reimbursement is not "appropriate" and Wal-Mart should be entitled only to that portion of Debbie's settlement that represented payments made by Wal-Mart for Debbie's medical expenses. Such a concept is embodied in the "pro rata loss sharing" method which was recently endorsed by this Court in *Arkansas Department of Health and Human Services, et al. v. Ahlborn,* 126 S.Ct. 1752 (2006).

For example, if we assume that the amount needed to compensate the beneficiary for all damages is $400,000, and we further assume that she is only able to recover $100,000, then the most that should be recoverable by the ERISA plan is one-fourth or 25% of its payments for medical bills since the beneficiary has been required to accept only 25% of her total damages by way of settlement. The ERISA plan's cause of action should face the same constraint upon recovery as that faced by the beneficiary. *See Ahlborn,* 126 S.Ct. 1752.

An examination of *Ahlborn* is instructive: In 1996, Heidi Ahlborn, a 19-year-old college student, suffered severe and permanent injuries, including brain damage, as a result of a car accident. *Ahlborn,* 126 S.Ct. at 1757. The Arkansas Department of Health Services ("ADHS") paid medical providers $215,645.30 on her behalf under the State's Medicaid plan. *Id.* Ahlborn then brought a claim against the third parties responsible for the injuries she sustained in the 1996 car accident. *Id.* She claimed damages not only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings

and working time; and permanent impairment of the ability to earn in the future. *Id.*

The ADHS sent letters to Ahlborn's attorney stating that, under Arkansas law, ADHS had a claim to reimbursement from "any settlement, judgment, or award" obtained by Alhborn from "a third party who may be liable for" her injuries, and that no settlement "shall be satisfied without first giving ADHS notice and a reasonable opportunity to establish its interest." *Id.* In 2002, Ahlborn settled her case for a total of $550,000. *Id.* The parties did not allocate the settlement between categories of damages. *Id.* ADHS did not participate or ask to participate in the settlement negotiations, however, ADHS asserted a lien against the settlement proceeds in the amount of $215,645.30 – the total cost of payments made by ADHS for Ahlborn's care. *Id.*

Ahlborn then filed an action in the United States District Court for the Eastern District of Arkansas seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses. *Id.* The parties stipulated that Ahlborn's entire claim was reasonably valued at over $3 million dollars and that the settlement amounted to approximately one-sixth of that sum. *Id.* The District Court held that Ahlborn had assigned to ADHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit and accordingly ADHS was entitled to a lien in the amount of $215,645.30. *Id.* at 1758. However, the Eighth Circuit reversed, holding that ADHS was "entitled only to that portion of the judgment

[$35,581.47] that represented payments for medical care." *Id.* This Court affirmed, stating:

> There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care ... And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs ... But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property.

Id. at 1763.

The Eighth Circuit held that *Ahlborn* was not applicable to the case at hand because ERISA, unlike Medicaid, does not limit Wal-Mart's right to reimbursement, and the Wal-Mart plan provides for "first priority" over any settlement or judgment obtained by Debbie. However, The Honorable Justice Stevens, the author of the unanimous *Ahlborn* decision, specifically addressed the equitable disposition of *Ahlborn* in the oral argument in *Sereboff*, an ERISA reimbursement case. In the colloquy between Justice Stevens and the attorney for the ERISA plan in *Sereboff*, Justice Stevens took the plan to task for seeking first priority reimbursement and suggested that such was not equitable:

> JUSTICE STEVENS: Well, are you – do you contend it's always applied first to the medical damages? In other words, supposing

there was – instead of the $750,000 settlement, it had been $100,000 here. $75,000 was medical, and they had a lot of substantial other claims, pain, suffering, loss of earnings, and so forth. Would you always get your full amount if – if the amount of the settlement is over the amount of the medical expense?

MR. COLEMAN: I think we would be entitled to it under the – the terms of the plan.

JUSTICE STEVENS: You think that's the equitable rule?

MR. COLEMAN: Obviously, in – in doing those things, there's a practical side on – on the business side when they work these things out. But the reason that claim would settle for $100,000 again speaks to the strength of their claim for other kinds of damages.

JUSTICE STEVENS: Well, it might be because – it might be because there's contributory negligence, all sorts of things. They might have compromised at 20 cents on the dollar across the board. Why should you get 100 cents when they – when the rest of the recovery only gets 20 – 20 cents?

MR. COLEMAN: Again, it's – it's because of the nature of the allocation.

JUSTICE STEVENS: That's equitable in your view? What?

MR. COLEMAN: It is because –

JUSTICE STEVENS: You think that's the equitable rule.

MR. COLEMAN: Yes. Courts in equity in – in – modern courts in equity in – in analyzing these types of – of claims have permitted these types of allocation -

JUSTICE STEVENS: And some do, but some do not I think.

Transcript of Oral Argument at 33-34 in *Sereboff*, 126 S.Ct. 1869 (No. 05-260), *available at* http://www.supremecourtus.gov/oral_arguments/argument_transcripts/05-260.pdf. Importantly, Justice Stevens authored the unanimous *Ahlborn* decision which, at the time of the *Sereboff* oral argument, was under consideration by this Court.

As in *Ahlborn,* no portion of Debbie's settlement was earmarked for past medical expenses paid for by Wal-Mart. Reimbursing Wal-Mart from her inadequate settlement would operate to deprive Debbie of her legal redress and compensation for her injuries. As stated above, Debbie recovered at settlement only a portion of her actual damages due to the limited liability insurance of the tortfeasors in her personal injury action. The trial court admitted into evidence Debbie's life care plan which estimated Debbie's total *future* economic loss in an amount exceeding twelve and one-half million dollars. Thus, it is unfair and incorrect for Wal-Mart to suggest that the net amount of settlement represents funds paid to

her primarily for reimbursement of *past* medical expenses.

The Shanks respectfully suggest that the reasoning this Court set forth in *Ahlborn* should be applied to the facts at hand. As this Court has held, the principal purpose of ERISA is "to protect plan participants and beneficiaries." *Boggs v. Boggs*, 520 U.S. 833, 845 (1997). However, if Wal-Mart is permitted to take its reimbursement for medical expenses out of settlement funds that compensated other losses, Debbie will not only fail to be protected – she will be deprived of the economic and non-economic damages to which she is entitled under state law. *See Ahlborn*, 126 S.Ct. at 1765 (recognizing that a rule of "absolute priority" would preclude settlement and be unfair to the recipient).

Finally, the Eighth Circuit stated in its opinion that "all other plan members would bear the cost in the form of higher premiums" if it was to deny Wal-Mart's claim to full reimbursement. App. 9a. Historically, however, subrogated recoveries are not reflected in the setting of rates. Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer L. Rev. 595, 627-31 (2004). It is the obligation of the insurer to establish rates and premiums which are based on the probability of medical need for everyone in the pool, regardless of the cause of injury. It is also the insurer's obligation to pay the insured's medical bills without regard to the cause of injury or the possibility that those injured by tortfeasors may obtain a settlement from which the insurer may seek subrogation. *Id.*

Denying Wal-Mart full reimbursement will have little, if any, effect on the Plan, however it will devastate the Shanks and leave them financially destitute.

Absent granting the Shanks' Petition for Writ of Certiorari, the devastating losses the Shanks have suffered as a result of a third party's negligence, which have dramatically altered their past, present and future lives, will be magnified by the fact that the special needs trust, which was established for Debbie's future medical care, will be depleted and the Shanks will be left with no money to pay for her care which will be required every day for the rest of her life. Justice demands that the Shanks at least be allowed a judicial determination, based on evidence presented, of the "appropriate" amount of equitable reimbursement.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
EIGHTH CIRCUIT

No. 06-3531

[Filed August 31, 2007]

ADMINISTRATIVE COMMITTEE OF THE WAL-MART STORES, INC. ASSOCIATES' HEALTH AND WELFARE PLAN,
Appellee,

v.

JAMES A. SHANK, as Trustee of Deborah J. Shank Irrevocable Trust; Deborah J. Shank; Deborah J. Shank Irrevocable Trust,
Appellants.

Before WOLLMAN, BEAM, and COLLOTON, Circuit Judges.

COLLOTON, Circuit Judge.

The Administrative Committee of the Wal-Mart Associates' Health and Welfare Plan ("the Committee") brought suit under section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), against James A. Shank, Deborah J. Shank, and the Deborah J. Shank Irrevocable Trust

("the Shanks"). The Committee sought reimbursement for $469,216 it had paid in medical expenses on behalf of Deborah Shank. The district court[1] granted summary judgment for the Committee, and the Shanks appeal. We affirm.

I.

Deborah Shank ("Shank") was a Wal-Mart employee and a member of the Associates' Health and Welfare Plan ("the Plan"), a self-funded employee benefit plan regulated by ERISA. In May 2000, Shank was severely injured in a car accident, and was eventually adjudicated an incompetent. Pursuant to the terms of the Plan, the Committee paid for the full amount of Shank's medical expenses related to the accident, a total of $469,216. Shank eventually filed a lawsuit against the parties responsible for her injuries, and in 2002, she obtained a settlement of $700,000. After deducting attorney's fees and costs, the district court placed the remaining $417,477 from the settlement into a special needs trust, with Shank as the beneficiary and her husband, James Shank, the trustee.

The Plan contains a subrogation and reimbursement clause that grants the Committee first priority over any judgment or settlement Shank received relating to the accident, so the Committee

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[1] The Honorable Lewis M. Blanton, United States Magistrate Judge for the Eastern District of Missouri, to whom the case was referred for final disposition by consent of the parties pursuant to 28 U.S.C. § 636(c).

may recover in full the amount it paid on Shank's behalf. After the Committee earned of Shank's settlement agreement, it sought to enforce the Plan's reimbursement provision, bringing suit under section 502(a)(3) of ERISA against Deborah Shank, James Shank, and the special needs trust. The district court granted summary judgment for the Committee and imposed a constructive trust on the funds in the special needs trust, in an amount not to exceed $469,216. The Shanks appeal the judgment of the district court. Reviewing the district court's decision *de novo,* we affirm.

II.

Section 502(a)(3) of ERISA authorizes a civil action by a plan "participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). The parties agree that the Committee is a fiduciary and that it brought suit to enforce the terms of the Plan. The applicable Plan provision obligates Shank to reimburse the Committee from any judgment or settlement that she receives, up to the full amount the Committee paid on her behalf. At issue in this appeal is whether the Committee's claim for full reimbursement sought "appropriate equitable relief" as authorized by section 502(a)(3).

In their brief, the Shanks argued that the Committee sought money damages, a form of legal rather than equitable relief. *See Mertens v. Hewitt*

Assocs., 508 U.S. 248, 255, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993). They contended that this court lacks subject matter jurisdiction because the Committee's claim does not fall under section 502(a)(3). The Shanks appeared to abandon this assertion at oral argument, and we reject it.

In *Sereboff v. Mid Atlantic Medical Servs., Inc.*, __ U.S. __, 126 S.Ct. 1869, 164 L.Ed.2d 612 (2006), the Supreme Court concluded that "equitable relief" under section 502(a)(3) includes a claim for restitution, in the form of a constructive trust or equitable lien, where the plaintiff seeks to recover "specifically identifiable" funds, that are due the plaintiff under the terms of the plan, and that are within the defendant's "possession and control." *Id.* at 1874; *see also Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002). In *Sereboff*, the plan administrator, much like the Committee in this case, sought reimbursement of medical expenses from an investment account that contained funds the Sereboffs had obtained in a tort settlement. The Court held that the reimbursement provision of the plan "specifically identified a particular fund, distinct from the Sereboff's general assets . . . and a particular share of that fund to which Mid Atlantic was entitled." *Sereboff*, 126 S.Ct. at 1875. Therefore, the Court concluded, "Mid Atlantic could rely on a 'familiar rul[e] of equity' to collect for the medical bills it had paid on the Sereboff's behalf." *Id.* (quoting *Barnes v. Alexander*, 232 U.S. 117, 121, 34 S.Ct. 276, 58 L.Ed. 530 (1914)).

The Committee's claim meets *Sereboff*'s requirements for equitable restitution: it seeks (1) the

specific funds it is owed under the terms of the plan-i.e., the money it paid to cover Shank's medical expenses; (2) from a specifically identifiable fund that is distinct from the Shank's general assets-i.e., the special needs trust; and (3) that is controlled by defendant James Shank, the trustee. *See Admin. Comm. of Wal-Mart Assocs. Health and Welfare Plan v. Willard,* 393 F.3d 1119, 1122-1125 (10th Cir.2004); *Admin. Comm. of Wal-Mart Stores, Inc. v. Varco,* 338 F.3d 680, 687-688 (7th Cir.2003); *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot, & Wansbrough,* 354 F.3d 348, 356-358 (5th Cir.2003). Therefore, we conclude that the Committee's suit seeks equitable relief under section 502(a)(3).[2]

The remaining issue is whether the relief the Committee sought was "appropriate." The Supreme Court in *Sereboff* declined to expound on the meaning of this term, because Sereboff's argument on that point had not been raised in the court below. 126 S.Ct. at 1877 n. 2. The Shanks contends that full reimbursement to the Committee is not "appropriate" under section 502(a)(3), and asks us to apply either the "make-whole" doctrine or a *pro rata* share requirement as a rule of federal common law in order to reach this conclusion. According to the make-whole doctrine, the

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[2] In their brief, the Shanks also argued that the Summary Plan Description (SPD), which contains the subrogation and reimbursement clauses at issue in this case, was not part of the 2001 Plan Wrap Document that governed the dispute. The Shanks abandoned this claim at oral argument, and it is foreclosed by our decision in *Admin. Comm. of the Wal-Mart Stores, Inc. v. Gamboa,* 479 F.3d 538 (8th Cir.2007), which held that the SPD is part of the 2001 Plan Wrap Document. *Id.* at 540, 544-545.

Committee would not be permitted to enforce its contractual right to reimbursement unless Shank were first made whole, that is, fully compensated for her injuries. *See*16 Lee R. Russ et. al., *Couch on Insurance* § 223:134 (3d ed. 2000). Under a *pro rata* share model, the Committee would receive only partial reimbursement equal to the share of Shank's settlement that compensates her for medical expenses. *See Sunbeam-Oster Co., Inc. v. Whitehurst,* 102 F.3d 1368, 1373-1374 (5th Cir.1996).

We are not persuaded that the Committee's full recovery according to the terms of the plan is not "appropriate" relief within the meaning of ERISA. The Supreme Court has recognized that Congress intended for the federal courts "to develop a federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) (internal quotation omitted). But the Court nonetheless has proven "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA," and has declined to create remedies beyond those Congress expressly authorized. *Mass. Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 147, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). In view of this cautious approach, we generally adopt new rules of federal common law only if they are necessary to fill gaps left by the express provisions of ERISA and to effectuate the purposes of the statute. *See, e.g., Varco,* 338 F.3d at 691; *Waller v. Hormel Foods Corp.,* 120 F.3d 138, 141 (8th Cir.1997); *see also Bollman Hat Co. v. Root,* 112 F.3d 113, 118 (3d Cir.1997) (federal courts may adopt a common law principle under ERISA "only if necessary to fill in interstitially or otherwise

effectuate the statutory pattern enacted in the large by Congress") (internal quotation omitted).

In *Waller,* for example, we held that make-whole is not a rule of federal common law that governs our interpretation of the written provisions of ERISA-regulated benefit plans. 120 F.3d at 139-40. We concluded that the terms of the written plan in that case entitled the administrator to full subrogation, regardless of whether the employee had been fully compensated for his injuries. *Waller* recognized that the make-whole doctrine originated in the law of insurance, where the overriding purpose of an insurance policy is to fully compensate the insured in case of loss, but that many ERISA-regulated benefit plans do not share that purpose. We thus concluded that the make-whole doctrine does not carry over from the insurance context to ERISA. *Waller* did not involve an interpretation of section 502(a)(3)'s reference to "appropriate equitable relief," but nothing in that provision counsels a different result.

The Supreme Court has directed that when courts consider the meaning of "appropriate" equitable relief, they should "keep in mind the special nature and purpose of employee benefit plans." *Varity Corp. v. Howe,* 516 U.S. 489, 515, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996) (internal quotation omitted). Among the primary purposes of ERISA is to ensure the integrity of written plans and to protect the expectations of participants and beneficiaries. *See, e.g., United McGill Corp. v. Stinnett,* 154 F.3d 168, 172 (4th Cir.1998); *Duggan v. Hobbs,* 99 F.3d 307, 309-310 (9th Cir.1996). Ordinarily, courts are to enforce the plain language of an ERISA plan "in accordance with 'its literal and

natural meaning.'" *United McGill,* 154 F.3d at 172 (quoting *Health Cost Controls v. Isbell,* 139 F.3d 1070, 1072 (6th Cir.1997)). We therefore do not apply common law theories to alter the express terms of a written plan. *See Varco,* 338 F.3d at 692; *Health Cost Controls,* 139 F.3d at 1072; *Singer v. Black & Decker Corp.,* 964 F.2d 1449, 1452 (4th Cir.1992); *Van Orman v. Am. Ins. Co.,* 680 F.2d 301, 312 (3d Cir.1982). This is especially true in the context of section 502(a)(3), which "does not, after all, authorize 'appropriate equitable relief' *at large,* but only 'appropriate equitable relief' for the purpose of . . . 'enforc[ing] any provisions' of ERISA or an ERISA plan." *Mertens,* 508 U.S. at 253, 113 S.Ct. 2063.

In this case, the Plan is clear about the rule of recovery. It states:

> The Plan has the right to . . . recover or subrogate 100 percent of the benefits paid by the Plan on your behalf . . . to the extent of . . . [a]ny judgment, settlement, or any payment made or to be made, relating to the accident. . . . These rights apply regardless of whether such payments are designated as payment for . . . [m]edical benefits [or] [w]hether the participant has been made whole (i.e., fully compensated for his/her injuries). . . . The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.

(App. 117-118).

To avoid this straightforward plan language, the Shanks argue that the make-whole rule is necessary to

achieve what the Supreme Court has called the "principal object" of ERISA: to protect plan participants and beneficiaries. *Boggs v. Boggs,* 520 U.S. 833, 845, 117 S.Ct. 1754, 138 L.Ed.2d 45 (1997). If the Committee is permitted full reimbursement, the Shanks contend, beneficiaries whose tort settlements cover only a small fraction of their injuries will be left without protection, and will be no better off than if they had not joined the Plan.

We acknowledge the difficulty of Shank's personal situation, but we believe the purposes of ERISA are best served by enforcing the Plan as written. Shank would benefit if we denied the Committee its right to full reimbursement, but all other plan members would bear the cost in the form of higher premiums. *See Harris v. Harvard Pilgrim Health Care, Inc.,* 208 F.3d 274, 280-81 (1st Cir.2000). Reimbursement and subrogation provisions are crucial to the financial viability of self-funded ERISA plans, and, as a fiduciary, the Committee must "preserve assets to satisfy future, as well as present, claims," and must "take impartial account of the interests of all beneficiaries." *Varity Corp.,* 516 U.S. at 514, 116 S.Ct. 1065.

Moreover, while ERISA is designed to protect the interests of plan participants and beneficiaries, those interests are specified by the written plan. ERISA's "repeatedly emphasized purpose [is] to protect *contractually defined* benefits." *Russell,* 473 U.S. at 148, 105 S.Ct. 3085 (emphasis added). Thus, while some courts have adopted the make-whole doctrine as a default rule of federal common law in the absence of contractual terms that specify a rule of recovery, these

courts recognize that such a common-law rule is inapplicable in the face of clear plan language to the contrary. *See Copeland Oaks v. Haupt,* 209 F.3d 811, 813 (6th Cir.2000); *Cagle v. Bruner,* 112 F.3d 1510, 1521 (11th Cir.1997); *Barnes v. Indep. Auto. Dealers Ass'n of Cal. Health & Welfare Benefit Plan,* 64 F.3d 1389, 1395 (9th Cir.1995).

The written Plan in this case confers benefits on both parties. Shank contributed premium payments, plus a promise to reimburse the Committee for medical expenses in the event she was injured and received a judgment or settlement from third parties. In exchange, she received the certainty that the Committee would pay her medical bills immediately if she was injured. *See Varco,* 338 F.3d at 692; *Cutting v. Jerome Foods, Inc.,* 993 F.2d 1293, 1298 (7th Cir.1993). Nothing in the statute suggests Congress intended that section 502(a)(3)'s limitation of the Committee's recovery to "appropriate equitable relief" would upset these contractually-defined expectations. Indeed, ERISA's mandate that "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), establishes the primacy of the written plan. Therefore, we reject Shank's assertion that the make-whole doctrine limits the Committee's contractual right to recovery.

The Shanks' *pro rata* theory fares no better. Citing *Arkansas Department of Health & Human Services v. Ahlborn,* 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), the Shanks argue that the Committee's right of reimbursement is limited to the portion of her settlement that covers her medical expenses. The

Shanks claim that Deborah Shank's damages from the accident were over $12 million dollars, and reason that because her settlement of $700,000 amounted to only 5.4% of her total damages, the Committee likewise is entitled to only 5.4% of the money it paid on her behalf, for a total of about $25,000.

Ahlborn does not support this result. The Supreme Court there addressed a state law that required Medicaid recipients who obtained a judgment or settlement against a third party to reimburse the State for all payments made on their behalf. The Court concluded that the state reimbursement statute "squarely conflicts with the . . . federal Medicaid laws," which entitled a State to only that portion of a judgment or settlement that covered medical expenses. *Id.* at 1760, 1761-1763. *Ahlborn* thus turned on the application of the federal Medicaid statute. ERISA, by contrast, does not limit the Committee's right to reimbursement. Some employee benefit plans explicitly provide for *pro rata* reimbursement, *see, e.g., Springs Valley Bank & Trust Co. v. Carpenter,* 885 F.Supp. 1131, 1143 (S.D.Ind.1993), but Shank and the Committee reached a different bargain, agreeing that she would reimburse the Committee in full, and granting the Committee first priority over any settlement or judgment she obtained. The Shanks' *pro rata* theory thus fails for the same reason as does her make-whole theory: federal courts lack authority to fashion a rule of federal common law that conflicts with the written plan and that is unnecessary to achieve the purposes of ERISA. *See Harris,* 208 F.3d at 280-281; *Sunbeam-Oster,* 102 F.3d at 1375-1376. ERISA's purposes of upholding the integrity of written plans and protecting the interest and expectations of

all participants and beneficiaries are best served by enforcing the Committee's contractual right to reimbursement. We thus hold that such relief is "appropriate" under section 502(a)(3).

* * *

For these reasons, the judgment of the district court is affirmed.

APPENDIX B

UNITED STATES DISTRICT COURT,
EASTERN DISTRICT OF MISSOURI
SOUTHEASTERN DIVISION

No. 1:05 CV 00129 LMB

[Filed August 31, 2006]

ADMINISTRATIVE COMMITTEE OF THE WAL-MART STORES, INC. ASSOCIATES' HEALTH AND WELFARE PLAN, Plaintiff,	)
v.	)
JAMES A. SHANK, as Trustee of the Deborah J. Shank Irrevocable Trust, Deborah J. Shank and the Deborah J. Shank Irrevocable Trust, Defendants.	)

MEMORANDUM AND ORDER

LEWIS M. BLANTON, Magistrate Judge.

This matter is before the court on the Complaint of Plaintiff Administrative Committee of The Wal-Mart Stores, Inc. Associates' Health and Welfare Plan for equitable relief and damages pursuant to the Employee Retirement Income Security Act of 1974

("ERISA"), 29 U.S.C. § 1132(a)(2) and (a)(3). This case has been assigned to the undersigned United States Magistrate Judge pursuant to the Civil Justice Reform Act and is being heard by consent of the parties. *See* 28 U.S.C. § 636(c).

Currently pending before the court is Plaintiff's Motion for Summary Judgment (Document Number 10), along with a Statement of Uncontroverted Material Facts (Doc. No. 10), Memorandum in Support (Doc. No. 11), and Index of Evidence (Doc. No. 12). Defendants have filed a Memorandum in Opposition to Plaintiff's Motion for Summary Judgment (Doc. No. 21), and plaintiff has filed a Reply (Doc. No. 25).

Background

On August 8, 2005, plaintiff filed its Complaint for equitable relief and damages under ERISA and federal common law for recovery of sums paid by the Wal-Mart Stores, Inc. Associates Health and Welfare Plan ("Plan") for medical services received by Defendant Deborah J. Shank. (Doc. No. 1). Plaintiff, the Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan ("Administrative Committee") is the "named fiduciary" of the Plan, which is an employee welfare benefit plan within the meaning of ERISA. Plaintiff is pursuing this action on behalf of the Plan.

The facts in this matter are undisputed. Defendant Deborah J. Shank incurred significant medical expenses after sustaining injuries in an automobile accident on May 12, 2000. Ms. Shank submitted a claim to the Plan, which paid the medical bills in an

amount exceeding $469,216.00. Ms. Shank sued the parties responsible for causing her injuries and settled her claims for $700,000 on August 8, 2002. After payment of attorney fees and costs, Ms. Shank received $417,477.00, which was placed in a special needs trust ("Trust") created for the benefit of Ms. Shank, with Ms. Shank's husband, James A. Shank to serve as Trustee.

Plaintiff alleges that, pursuant to the terms of the Plan, the Plan has the right to be reimbursed from the proceeds of any settlement Ms. Shank received for the injuries she incurred and for which the Plan paid the benefits. Plaintiff states that the Plan advised Ms. Shank and her attorneys that they must inform the Plan before she settled her suit, but Ms. Shank did not notify the Plan of the settlement until after October 9, 2002, well after the settlement had been completed and the proceeds had been placed in the Trust. Plaintiff claims that defendants' failure to reimburse the Plan the full amount of the settlement is a violation of the terms of the Plan. Plaintiff requests that the court grant a declaratory judgment in its favor, injunctive relief, specific performance, impose a constructive trust, and grant it restitution from and against James A. Shank as Trustee and the Deborah J. Shank Irrevocable Trust ordering James A. Shank as Trustee to turn over to the Plan the settlement proceeds in the amount of at least $469,216.00 for the medical bills paid on Ms. Shank's behalf. In addition, the plaintiff seeks attorney's fees, interest, and costs. Plaintiff also alleges that defendants breached their fiduciary duty to the Plan to use the assets only for the benefit of the Plan and its beneficiaries, and not for their own use. Plaintiff thus requests that the court

award it damages for the amount of the medical bills paid on Ms. Shank's behalf and not reimbursed to the Plan, in addition to attorney fees, interest, and costs.

Plaintiff filed a Motion for Preliminary Injunction, which the court granted on June 9, 2006. (Docs. No. 14, 29). The preliminary injunction enjoined defendants from dispersing the remaining settlement proceeds held in the Trust, except as specifically listed in the injunction.

Discussion

A. *Summary Judgment Standard*

A court may grant summary judgment when no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law, according to Federal Rule of Civil Procedure 56(c). A fact is material only when its resolution affects the outcome of the case. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 2510, 91 L.Ed.2d 202 (1986). A dispute is genuine if the evidence is such that it could cause a reasonable jury to return a verdict for either party. *See id.* at 252, 106 S.Ct. at 2512. In deciding a motion for summary judgment, the court must review the facts and all reasonable inferences in a light most favorable to the nonmoving party. *See Canada v. Union Elec. Co.*, 135 F.3d 1211, 1212 (8th Cir.1997).

In a motion for summary judgment, the movant bears the initial burden of proving the absence of any genuine issue of material fact that would preclude judgment for the movant. *See City of Mt. Pleasant,*

Iowa v. Associated Elec. Co-op, Inc., 838 F.2d 268, 273 (8th Cir. 1988). Once the movant has met this burden, the non-movant may not rely on mere denials or bare allegations, but must point to specific facts that raise a triable issue. *See Anderson*, 477 U.S. at 249, 106 S.Ct. at 2510-2511. The non-movant must set forth specific facts, by affidavit or otherwise, sufficient to raise a genuine issue of material fact for trial. *See Celotex Corp. v. Citrate*, 477 U.S. 317, 324, 106 S.Ct. 2548, 2553, 91 L.Ed.2d 265 (1986). The Supreme Court has found that "[s]ummary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy, and inexpensive determination of every action.'" *Id.* at 327, 106 S.Ct. at 2555 (quoting Fed.R.Civ.P. 1).

B. *Plaintiff's Motion For Summary Judgment*

Plaintiff argues that judgment should be entered in its favor because no genuine issue of material fact exists as to the Plan's right to reimbursement and subrogation. Specifically, plaintiff claims that the plain language of the Plan entitles it to first priority in Ms. Shank's settlement proceeds and defendants have failed to comply with the terms of the Plan document. Plaintiff contends that it is entitled to equitable relief, including a constructive trust, to enforce its reimbursement interest in the settlement proceeds. Plaintiff further argues that it is entitled to damages, in the amount of Ms. Shank's medical bills the Plan paid for injuries sustained in the accident, for defendants' breach of their fiduciary duties.

In their Memorandum in Opposition to Plaintiff's Motion for Summary Judgment, defendants first argue that this court lacks jurisdiction under ERISA. Defendants next claim that plaintiff has not produced sufficient evidence to establish as a matter of law that its claim for reimbursement is based upon a reasonable interpretation of the Plan's terms. Specifically, defendants contend that there is no evidence that the Summary Plan Description, upon which plaintiff relies in its claim for reimbursement, is a valid part of the Plan. Defendants argue that, even if there were sufficient evidence to establish that plaintiff's claim for reimbursement is in accordance with the Plan's terms, plaintiff's claim is not for "appropriate equitable relief," it is not "appropriate," and it does not serve public policy or the purpose of ERISA. Defendants further argue that they did not breach any fiduciary duty owed to plaintiff. Finally, defendants contend that equitable reimbursement should allow repayment of the Plan only after Ms. Shank has been made whole.

Plaintiff, in its Reply, responds to defendants' various arguments. Plaintiff contends that defendants have failed to establish the presence of a material issue of fact. The undersigned agrees. For the reasons set forth below, plaintiff's Motion for Summary Judgment will be granted.

1. Subject Matter Jurisdiction

Defendants first argue that this court lacks subject matter jurisdiction over this suit because plaintiff is seeking monetary damages under a breach of contract

theory, and not "appropriate equitable relief" under ERISA. § 502(a)(3), 29 U.S.C. § 1132(a)(3).

ERISA authorizes a civil action "by a . . . fiduciary (A) to enjoin any act or practice which violates . . . the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of . . . the terms of the plan." 29 U.S.C. § 1132(a)(3). The Eighth Circuit has held that a fiduciary's claim against a plan participant for specific performance of the plan's subrogation and reimbursement clause falls within the exclusive jurisdiction of ERISA. *See Lyons v. Philip Morris, Inc.*, 225 F.3d 909, 913 (8th Cir.2000).

The United States Supreme Court distinguished between legal and equitable restitution in *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002). In *Great-West,* an ERISA plan brought an action for specific performance of a reimbursement provision and to compel a plan beneficiary who had recovered from a third party to make restitution to the plan for benefits that it had paid. The Supreme Court held that Section 502(a)(3) did not authorize the suit against the beneficiary for reimbursement where the settlement funds had already been distributed to a special needs trust for the beneficiary's care, to the beneficiary's attorney, and to various lien holders. *Id.* at 214, 122 S.Ct. 708. The Court found that the action could not be characterized as equitable relief because it sought to impose personal liability on the beneficiary for benefits it had conferred upon her, which was a legal remedy. *Id.* at 214, 122 S.Ct. 708. The Court, however, acknowledged that a plaintiff could seek restitution in

equity, "ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." *Id.* at 213, 122 S.Ct. 714. In a recent case, *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S.Ct. 1869 (2006), the Supreme Court, applying *Great-West,* held that an ERISA plan's action to recover amounts paid for medical expenses from a plan beneficiary was a proper action for equitable relief under ERISA where the plan sought recovery through a constructive trust on a specifically identifiable fund.

Here, plaintiff claims that it is entitled to a portion of the settlement proceeds pursuant to the terms of the Plan. Unlike the plaintiff in *Great-West,* the Administrative Committee has sued the trustee of the special needs trust, the individual who has possession of the funds. In addition, plaintiff seeks equitable restitution, including the imposition of a constructive trust, to restore to plaintiff particular funds in the defendants' possession, rather than the imposition of personal liability upon the trustee of the special needs trust as was sought in *Great-West.* As such, this court has exclusive jurisdiction over plaintiff's action under ERISA.

Although in the present case the proceeds awarded as a result of the personal injury suit were placed in a special needs trust, this was done after the equitable lien of the Plan had been asserted and acknowledged. *See* Ex. 10, Letter of June 27, 2001 addressed to Gray, Ritter and Graham with the acknowledgment "The above is agreeable. Date 7-2-2001. Signed: Maurice B.

Graham." That lien and plaintiff's right of equitable restitution should not be defeated by the defendant's placing the funds into a special needs trust. As the Supreme Court stated in *Sereboff*:

> And as *Barnes* itself makes clear, other cases of this Court-not involving attorneys' contingency fees-apply the same "familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing."

126 S.Ct. at 1877 (quoting *Barnes v. Alexander*, 232 U.S. 117, 121, 34 S.Ct. 276, 278, 58 L.Ed. 530 (1914)).

2. Plaintiff's Right to Reimbursement and Subrogation

Plaintiff claims that the plain language of the Plan entitles it to first priority in Ms. Shank's settlement proceeds and defendants have failed to comply with the terms of the Plan. Defendants contend that inconsistencies exist between the Summary Plan Descriptions provided to Wal-Mart employees and the actual wording of the Plan.

It is settled that ERISA plan participants have an obligation to reimburse the plan when a recovery is made from a third party responsible for the injuries and the plan terms require reimbursement. *See Waller v. Hormel Foods Corp.*, 120 F.3d 138, 140 (8th Cir. 1997). A subrogation provision affects the level of benefits conferred by the plan, and ERISA leaves that issue to the private parties creating the plan. *Id.* As

such, plaintiff's claim turns on the proper interpretation of the Plan.

Plaintiff relies on the "Right to Reduction, Reimbursement and Subrogation" provision contained in the January 2000 Summary Plan Description (SPD). This provision provides in relevant part as follows:

> [t]he Plan has the right to 1) reduce or deny benefits otherwise payable by the Plan and 2) recover or subrogate 100 percent of the benefits paid or to be paid by the Plan on your behalf and or your dependents to the extent of any and all of the following payments: Any judgment, settlement or any payment made or to be made, relating to the accident, including but not limited to other insurance.

SPD at 19. The SPD further states that "[t]he Plan has first priority with respect to its right to reduction, reimbursement and subrogation." *Id.* at 20. In addition, the SPD provides that "[a]ll attorney's fees and court costs are the responsibility of the participant, not the Plan." *Id.* at 19.

Defendants do not dispute that the plain language of the SPD provides for the right of reimbursement and subrogation. Rather, at issue is whether the SPD is properly part of the Plan so that its reimbursement provision is enforceable against defendants. Defendants argue that the Plan consists only of the 1997 Associates' Health and Welfare Plan Wrap Document ("Wrap document"), which contains no such reimbursement provision.

The Eighth Circuit has held that summary plan descriptions are considered part of ERISA plan documents. *See Barker v. Ceridian Corp.*, 122 F.3d 628, 633 (8th Cir.1997) (citing *Jenson v. SIPCO, Inc.*, 38 F.3d 945, 949 (8th Cir. 1994)). Defendants rely on two Arkansas district court cases, *Administrative Committee of Wal-Mart Stores Inc. Associates' Health & Welfare Plan v. Gamboa,* 2006 WL 374764 (W.D. Ark. Feb. 7, 2006), and *Cossey v. Associates' Health & Welfare Plan,* 363 F.Supp.2d 1115 (E.D. Ark.2005), which held that a similar reimbursement provision was not enforceable against participants because it appeared only in the SPD and was not part of the Plan.*Gamboa* and *Cossey,* however, can be distinguished from the instant case. In both of these cases, the Arkansas district courts interpreted the 2001 Wrap document. The courts determined that, under the language of the 2001 Wrap document, summary plan descriptions were not included in the definition of the Plan. *See Gamboa,* 2006 WL 374764 at *4; *Cossey,* 363 F.Supp.2d at 1131. In the instant case, the 1997 Wrap document applies, because this is the document that was in effect at the time plaintiff was injured in 2000. Defendants do not dispute that the 1997 Wrap document applies in this case. Unlike the 2001 Wrap document interpreted in *Gamboa* and *Cossey,* the 1997 Wrap document defines the Plan to include summary plan descriptions.

The 1997 Wrap document defines "Plan" as follows: "'Plan' means the Associates Health and Welfare Plan, which consists of this document and each Welfare Program incorporated hereunder by reference, as amended from time to time." Def's Ex. 5 at 2. "Welfare Program" is defined, in relevant part, as "a written

arrangement, *including a summary plan description,* incorporated into this Plan that is offered by the Company which provides any employee benefit that would be treated as an 'employee welfare benefit plan' under Section 3(1) of ERISA if offered separately." *Id.* (emphasis added). The 1997 Wrap document further states that each Welfare Program is identified in Appendix A of the Wrap document. *See id.* Appendix A lists the "Wal-Mart Associates' Group Health Plan" as a Welfare Program "comprising the Plan." *Id.* at App. A. The 1997 Wrap document provides that "[n]otwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan . . ." Def's Ex. 5 at 1. The 2000 SPD, in turn, states that it is a Plan Summary for the Associates Health and Welfare Plan. *See* Def's Ex. 4 at S3. Plaintiff has also attached the Affidavit of Christy Herbaugh, Reimbursement Coordinator for the Plan, who states that the 2000 SPD is incorporated into the 1997 Wrap document. *See* Def's Ex. 3 at ¶ 5.

The undersigned finds that the 2000 SPD, which contains the reimbursement provision, is part of the Plan and is thus enforceable against defendants. This provision unambiguously gives the Plan first priority with respect to its right to reimbursement and subrogation from the proceeds of a settlement received for injuries incurred for which the Plan paid benefits. The Plan also requires that the beneficiary pay attorney's fees and costs incurred in achieving the settlement. As such, defendants were required to reimburse the Plan in the amount of the proceeds in the trust remaining from the settlement not to exceed $469,216.00, the undisputed amount the Plan paid in

Ms. Shank's medical bills that were incurred as a result of the accident.

Plaintiff has demonstrated that no genuine issues of material facts exist and plaintiff is entitled to judgment on the merits. The court finds that plaintiff's request for a constructive trust is appropriate equitable relief under the circumstances. Thus, the court will impose a constructive trust on the settlement proceeds currently held in the Deborah J. Shank Irrevocable Trust not to exceed $469,216.00. The court declines to award attorney's fees or interest to plaintiff. *See Givens v. Wal-Mart Stores, Inc. and Associates' Health and Welfare Plan,* 327 F.Supp.2d 1063, 1067 (D. Neb.2004).

In its Motion for Summary Judgment, besides seeking the imposition of a constructive trust and an order that James A. Shank as Trustee turn over the settlement proceeds in the trust, plaintiff asks for damages for the Shanks' breach of fiduciary duty. This relief is denied.

Accordingly,

IT IS HEREBY ORDERED that Plaintiff Administrative Committee of The Wal-Mart Stores, Inc. Associates' Health and Welfare Plan's Motion for Summary Judgment (Doc. No. 10), be and it is **granted.** A separate order of Summary Judgment will be entered on this date.

IT IS FURTHER ORDERED that the court imposes a constructive trust on the settlement

proceeds currently held in the Deborah J. Shank Irrevocable Trust not to exceed $469,216.00.

IT IS FURTHER ORDERED that James A. Shank, Trustee of the Deborah J. Shank Irrevocable Trust, is directed to deliver the settlement proceeds currently held in the Deborah J. Shank Irrevocable Trust not to exceed $469,216.00 to Baird Holm LLP on behalf of the Administrative Committee of the Wal-Mart Stores Inc.'s Associates' Health and Welfare Plan.

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 06-3531

[Filed October 29, 2007]

ADMINISTRATIVE COMMITTEE OF THE WAL-MART STORES, INC. ASSOCIATES' HEALTH AND WELFARE PLAN,
Appellee,

v.

JAMES A. SHANK, as Trustee of Deborah J. Shank Irrevocable Trust, et al.,
Appellants.

Appeal from U.S. District Court for the Eastern District of Missouri - Cape Girardeau (1:05-cv-00129-LMB)

ORDER

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

Judge Murphy, Judge Bye, and Judge Melloy would grant the petition for rehearing en banc.

Judge Gruender and Judge Benton did not participate in the consideration or decision of this matter.

October 29, 2007

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit.

/s/ Michael E. Gans

APPENDIX D

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 - EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I - PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B - REGULATORY PROVISIONS
PART 5 - ADMINISTRATION AND ENFORCEMENT

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

* * *

Current through P.L. 110-131 approved 11-30-07

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No. 07-791

FILED
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OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE

Supreme Court of the United States

JAMES A. SHANK, AS TRUSTEE OF THE DEBORAH J. SHANK IRREVOCABLE TRUST, DEBORAH J. SHANK, AND THE DEBORAH J. SHANK IRREVOCABLE TRUST,

Petitioners,

v.

ADMINISTRATIVE COMMITTEE OF THE WAL-MART STORES, INC. ASSOCIATES' HEALTH AND WELFARE PLAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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QUESTION PRESENTED

Whether federal courts should impose a rule of federal common law based on the "make whole" or "pro rata" doctrines to limit an ERISA plan's right to reimbursement of benefits paid by the plan in the event of a participant's recovery from a third party despite unambiguous and undisputed plan language requiring full reimbursement.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding. Wal-Mart Stores, Inc., a publicly traded company, sponsors the self-funded Wal-Mart Stores, Inc. Associates' Health and Welfare Plan (the "Plan") within the meaning of ERISA, 29 U.S.C. § 1002(1). The Plan is not publicly-traded, has no parent corporation, and no publicly-held company owns 10% or more of the Plan's stock. Wal-Mart Stores, Inc. has no parent corporation, and no publicly-held company owns 10% or more of its stock.

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BRIEF IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-12a) is reported at 500 F.3d 834. The opinion of the district court (Pet. App. 13a-26a) is unofficially reported at 2006 WL 2546797.

JURISDICTION

The judgment of the court of appeals was entered on August 31, 2007. A petition for rehearing en banc was denied on October 29, 2007. Petitioners have invoked the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3), provides:

> A civil action may be brought by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

STATEMENT

1. Deborah J. Shank ("Petitioner") was a Wal-Mart employee and a member of the Associates' Health and Welfare Plan, Wal-Mart's self-funded employee benefit plan regulated by ERISA. The Plan provides that, in the event of an accident:

> The Plan has the right to . . . recover or subrogate 100 percent of the benefits paid by the Plan on your behalf . . . to the extent of . . . [a]ny judgment, settlement, or any payment made or to be made, relating to the accident . . . . These rights apply regardless of whether such payments are designated as payment for . . . [m]edical benefits [or] [w]hether the participant has been made whole (i.e., fully compensated for his/her injuries). . . . The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.

Pet. App. at 8a.

On May 12, 2000, Petitioner was injured in a car accident. In accordance with the terms of the Plan, and though Petitioner had been a participant in the Plan for just over three months, the Administrative Committee of the Wal-Mart Associates' Health and Welfare Plan (the "Committee") paid the full amount of Petitioner's medical expenses in connection with the accident, a total of $469,216. Petitioner filed a lawsuit against the parties responsible for the accident and obtained a settlement of $700,000. After attorneys' fees and costs were deducted, the remaining $417,477 was placed in a special needs trust for the benefit of Petitioner.

Though the Committee repeatedly advised Petitioner of her obligation to reimburse the Plan from any settlement she obtained and her duty to notify the Plan before settlement, it did not learn of Petitioner's settlement until after the proceeds from the settlement had already been placed in the trust.

Because Petitioner did not reimburse the Plan, the Committee, as the named fiduciary of the Plan, was compelled to bring suit in federal district court under section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), to enforce the Plan's terms and seek reimbursement for benefits the Plan paid on Petitioner's behalf.

2. The district court granted summary judgment to the Committee because the terms of the Plan "unambiguously give[ ] the Plan first priority with respect to its right to reimbursement and subrogation from the proceeds of a settlement received for injuries incurred for which the Plan paid benefits." Pet. App. 24a. In accordance with this Court's decisions in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006), the district court placed a constructive trust on the special needs trust in an amount not to exceed $469,216, the undisputed amount paid by the Plan for Petitioner's medical bills as a result of the accident.

3. Petitioner appealed the district court's judgment, arguing that, despite the Plan's clear language requiring Petitioner to reimburse the Committee in full for medical expenses paid on her behalf, full reimbursement was not "appropriate equitable relief" pursuant to section 502(a)(3) of ERISA. The court of appeals reviewed the district court's decision *de novo* and, keeping with the decisions of its sister circuits, affirmed in a unanimous opinion.

Applying this Court's decision in *Sereboff*, the court of appeals held that

> the Committee's claim [met] *Sereboff*'s requirements for equitable restitution

> [because] it [sought] (1) the specific funds it is owed under the terms of the plan—i.e., the money it paid to cover [Petitioner's] medical expenses; (2) from a specifically identifiable fund that is distinct from the Shank's general assets—i.e., the special needs trust; and (3) that is controlled by defendant James Shank, the trustee.

Pet. App. at 4a-5a. Petitioner does not challenge or seek review of this holding in this Court.

The court rejected Petitioner's argument that full reimbursement was not "appropriate" under section 502(a)(3) because Petitioner had not been "made whole" by the settlement she received. Pet. App. at 6a. Petitioner had urged the court to construct a "rule of federal common law" applying the "make-whole" or "pro rata" doctrine to override the Plan's explicit language requiring full reimbursement. *Id.* at 5a. Under the "make whole" doctrine adopted by some state courts in the insurance context, an insurer is not allowed to enforce a contractual right to reimbursement unless the insured is first "made whole," i.e., fully compensated for all her injuries. *See* 16 LEE R. RUSS ET AL., COUCH ON INSURANCE § 223:134 (3d ed. 2005). Similarly, the "pro rata" doctrine dictates that the insurer receive only partial reimbursement proportionate to the share of the insured's settlement that compensates her for medical expenses. *See CNA Ins. Cos. v. Johnson Galleries*, 639 So. 2d 1355, 1359 (Ala. 1994).

In reaching its decision, the court cited the consensus among the courts of appeals that common law theories must not be applied to "alter the express terms of a written plan." Pet. App. at 6a-7a. It

reasoned that "[n]othing in the statute suggests Congress intended that section 502(a)(3)'s limitation of the Committee's recovery to 'appropriate equitable relief' would upset . . . contractually-defined expectations." *Id.* at 10a. Noting this Court's holding that ERISA's "repeatedly emphasized purpose [is] to protect *contractually defined* benefits," *id.* at 9a (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)), the court rejected Petitioner's assertion that the "make-whole" and "pro rata" doctrines should trump the written ERISA Plan, Pet. App. at 11a.

Petitioner then sought rehearing en banc, reiterating the same arguments she made before the panel. The Eighth Circuit denied the petition.

REASONS FOR DENYING THE PETITION

Petitioner contends that certiorari is appropriate to address whether the "make whole" or "pro rata" doctrine should be applied as an exercise of federal common lawmaking to contravene the clear language of a written ERISA plan. But certiorari is unwarranted for three reasons. First, though Petitioner attempts to portray this question as one of first impression, Petitioner's argument has been considered and rejected decisively and consistently by the courts of appeals. Not only is there no conflict among the lower courts on this question, but the decision of the Eighth Circuit below is consistent with the decisions of ten other circuits—every circuit to have considered the issue.[1] Second, the decision of

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[1] The First, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, Eleventh, and D.C. Circuits have all considered the question presented and have rejected the "make whole" and

[Footnote continued on next page]

the court below correctly applies this Court's precedents in upholding the sanctity of a written ERISA plan against a request for the courts to re-write it. Lastly, enforcement of the Plan and reimbursement of the benefits it paid was just and reasonable under the circumstances. Accordingly, this Court's review is not warranted.

I. THERE IS NO CONFLICT AMONG THE LOWER COURTS ON THE QUESTION PRESENTED

The decision of the Eighth Circuit below is consistent with the decisions of all the courts of appeals to address the question presented. The Courts of Appeals for the First,[2] Third,[3] Fourth,[4]

[Footnote continued from previous page]
"pro rata" doctrines in the face of clear plan language requiring full reimbursement. *See infra*, nn.2-11. The Second Circuit has not yet had an opportunity to consider the question.

[2] *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280 (1st Cir. 2000) ("Where an ERISA plan requires—without qualification—that plan participants reimburse the plan for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine.").

[3] *Bollman Hat Co. v. Root*, 112 F.3d 113, 116-17 (3d Cir. 1997); *Ryan by Capria-Ryan v. Fed. Express Corp.*, 78 F.3d 123, 124 (3d Cir. 1996) (refusing to import "pro rata" doctrine because courts may not "override a subrogation provision in an ERISA-regulated plan on the ground that the plan would be unjustly enriched if it were to be enforced as written").

[4] *Kress v. Food Employers Labor Relations Ass'n*, 391 F.3d 563, 568 (4th Cir. 2004) (rejecting "make whole" doctrine in the face of clear plan language); *Paris v. Iron Workers Trust Fund, Local No. 5 (In re Paris)*, No. 99-1558, 2000 U.S. App. LEXIS 6883, *8-10 (4th Cir. Apr. 17, 2000) (unpublished); *United*

[Footnote continued on next page]

Fifth,[5] Sixth,[6] Seventh,[7] Ninth,[8] Tenth,[9] Eleventh,[10] and D.C.[11] Circuits *all* agree with the Eighth Circuit

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McGill Corp. v. Stinnett, 154 F.3d 168, 173 (4th Cir. 1998) (rejecting "pro rata" limitation on recovery because "the language of the Plan does not qualify the right to reimbursement by reference to the costs associated with recovery" and the court was "bound to enforce the contractual provisions as drafted").

5 *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938, 940 (5th Cir. 1998); *Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368, 1374-76 (5th Cir. . 1996) (unconditional plan provision implies reimbursement "to the full extent" of benefits previously paid, "regardless of [the] source").

6 *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997) (refusing to import "pro rata" doctrine because "federal courts may not apply common law theories to alter the express terms of written benefit plans"); *cf. Copeland Oaks v. Haupt*, 209 F.3d 811, 813 (6th Cir. 2000) (adopting "make whole" doctrine as a default rule in the absence of clear plan language requiring reimbursement).

7 *Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco*, 338 F.3d 680, 692 (7th Cir. 2003) ("[T]he unambiguous language of the Plan obligates her to repay the benefits paid in full without a pro rata deduction for her legal expenses, and thus any so-called enrichment is not unjust."); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298-99 (7th Cir. 1993) (Posner, J.) (holding that "the make-whole rule is just a principle of interpretation" that "can be overridden by clear language in the plan" and finding no abuse of discretion in plan administrator's interpretation of plan provision as precluding "make whole" doctrine).

8 *Barnes v. Indep. Auto. Dealers Ass'n of Cal. Health & Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995) ("We would not apply the interpretive 'make-whole rule' as a 'gap-filler' if the subrogation clause in the Plan document specifically allowed

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that the "make-whole" and "pro-rata" doctrines do not apply where the clear language of an ERISA plan requires full reimbursement.

Though only the D.C. Circuit and Eighth Circuit below have addressed the question when framed as an interpretation of "appropriate" equitable relief under section 502(a)(3), *see* Pet. App. at 5a-6a; *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 8-9 n.9 (D.C. Cir. 2006), every court of appeals to consider whether the "make whole" or "pro rata" doctrine should trump clear ERISA plan language requiring full reimbursement has answered the question in the negative. Petitioner's attempt to recast the question as one of statutory interpretation does not change

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the Plan the right of first reimbursement out of any recovery [the participant] was able to obtain even if [the participant] were not made whole.").

9 *Alves v. Silverado Foods, Inc.*, 6 Fed. Appx. 694, 703-04 (10th Cir. 2001) (unpublished) (rejecting "make whole" doctrine because the plan clearly required full reimbursement).

10 *Cagle v. Bruner*, 112 F.3d 1510, 1521 (11th Cir. 1997) ("As a default rule, the make whole doctrine applies to limit a plan's subrogation rights where an insured has not received compensation for his total loss *and the plan does not explicitly preclude operation of the doctrine.*" (emphasis added)).

11 *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 8-10 & n.9 (D.C. Cir. 2006) (rejecting "make whole" doctrine where plan "unambiguously establishes a plan priority to any third party recovery the beneficiary obtains regardless whether the beneficiary has been made whole by the recovery" and holding that such full reimbursement to the plan, even though the participant has not been "made whole," is "appropriate" under section 502(a)(3) of ERISA).

this fact. Because there is no conflict among the courts of appeals, and in light of their widespread agreement on this issue, this Court's review of the decision below is unwarranted.

II. THE DECISION OF THE COURT OF APPEALS BELOW IS CORRECT ON THE MERITS

ERISA's "repeatedly emphasized purpose [is] to protect contractually defined benefits." *Russell*, 473 U.S. at 148 (emphasis added). Accordingly, this Court has held that "the private parties, not the Government, control the level of benefits" provided by an ERISA plan. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981); *see also Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("ERISA [does not] mandate what kind of benefits employers must provide if they choose to have [an ERISA] plan."); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits"); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 277-78 (1st Cir. 2000) ("Since 'one of the primary functions of ERISA is to ensure the integrity of written, bargained-for benefit plans[,]' generally speaking ERISA does not mandate that a covered plan include particular substantive provisions." (alteration in original) (citation omitted)). It is therefore up to the parties to reach an agreement, memorialized in the form of an ERISA plan, as to the precise benefits conferred upon the plan's members in exchange for their payment of premiums. Accordingly, courts uniformly enforce clear plan language. *See, e.g., Admin. Comm. of the Wal-Mart Stores, Inc. v. Varco*, 338 F.3d 680, 691 (7th Cir. 2003); *United McGill Corp. v. Stinnett*, 154

F.3d 168, 172 (4th Cir. 1998) ("[T]he plain language of an ERISA plan must be enforced in accordance with 'its literal and natural meaning.'") (quoting *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997)); *Van Orman v. Am. Ins. Co.*, 680 F.2d 301, 312 (3d Cir. 1982); *cf. Barnes v. Alexander*, 232 U.S. 117, 122-23 (1914) (in a case relied upon in this Court's opinion in *Sereboff*, 126 S. Ct. 1869, rejecting the argument that a payment owed to the payee out of funds received by the payor should be reduced because the payor did not recover the full amount expected, and enforcing the terms of their agreement).

Though this Court has recognized the limited need for federal courts "to develop a federal common law of rights and obligations under ERISA-regulated plans," *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (internal quotations omitted), it has also warned against "tamper[ing] with an enforcement scheme crafted with such evident care as the one in ERISA," *Russell*, 473 U.S. at 147; *cf. Halcyon Lines v. Haenn Ship Ceiling & Refitting Corp.*, 342 U.S. 282, 285 (1952) (refusing to create a rule of federal common law in the heavily regulated area of maritime personal injuries). These two commands do not conflict; courts craft federal common law, but only in the absence of clear plan language. *See United McGill*, 154 F.3d at 171-72. Moreover, enforcing plans as written fulfills the parties' expectations and encourages employers to offer ERISA plans for the benefit of all employees. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (noting the public interest in encouraging the formation of employee benefit plans). For these reasons, federal courts have proceeded with the utmost caution when asked to adopt new rules of

federal common law in the ERISA context, doing so only if necessary to interpret ambiguous ERISA plan language. *See, e.g.*, *Van Orman*, 680 F.2d at 311-13; *Murphy v. Heppenstall Co.*, 635 F.2d 233, 237 (3d Cir. 1980).

Federal courts have therefore repeatedly refused to read the "make whole" doctrine into plans that clearly reject it. *See, e.g.*, *Harris*, 208 F.3d at 280 ("Where an ERISA plan requires—without qualification—that plan participants reimburse the plan for benefits paid, the plan should not be construed to depend upon an implied contingency such as the 'make whole' doctrine."); *Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368, 1374-76 (5th Cir. 1996) (unconditional plan provision implies reimbursement "to the full extent" of benefits previously paid, "regardless of [the] source"); *cf. Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1299 (7th Cir. 1993) (finding no abuse of discretion in plan administrator's interpretation of plan provision as precluding "make whole" doctrine). Similarly, courts have also refused to apply the "pro rata" doctrine where the language of the governing plan clearly dictates full reimbursement. *See, e.g.*, *United McGill*, 154 F.3d at 173 (rejecting "pro rata" limitation on recovery because "the language of the Plan does not qualify the right to reimbursement by reference to the costs associated with recovery" and the court was "bound to enforce the contractual provisions as drafted"); *Isbell*, 139 F.3d at 1072 (refusing to import "pro rata" doctrine because "federal courts may not apply common law theories to alter the express terms of written benefit plans"); *Ryan by Capria-Ryan v. Fed. Express Corp.*, 78 F.3d 123, 124 (3d Cir. 1996) (refusing to import "pro rata" doctrine because courts may not "override a

subrogation provision in an ERISA-regulated plan on the ground that the plan would be unjustly enriched if it were to be enforced as written"); *cf. Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1997) (agreeing with above authority, but implying "pro rata" offset as a default rule because the plan did not provide otherwise).

In an effort to reopen this settled question, Petitioner attempts to portray it as one of statutory interpretation, arguing that ERISA's requirement that "equitable relief" be "appropriate," § 1132(a)(3), somehow requires courts to impose the "make whole" or "pro rata" doctrine to override clear plan language to the contrary. But framing the question as one of statutory interpretation does not change the answer. In *Sereboff*, this Court held that "equitable relief" under section 502(a)(3) includes equitable restitution in the form of a constructive trust where the ERISA plan seeks "specifically identifiable funds" that are in the participant's control and owed pursuant to the plan. 126 S. Ct. at 1874. Petitioner does not dispute or seek review of the holding of the courts below that the relief granted to the Plan in this case was "equitable" under *Sereboff*. Instead, Petitioner argues that this relief was not "appropriate" under section 502(a)(3). While *Sereboff* declined to address the meaning of "appropriate," 126 S. Ct. at 1877 n.2, this Court's ERISA decisions, which have been interpreted uniformly by eleven courts of appeals to bar application of the "make whole" and "pro rata" doctrines where they contradict clear plan language, preclude Petitioner's claim. Section 502(a)(3) "does not, after all, authorize 'appropriate equitable relief' at large, but only 'appropriate equitable relief' for the purpose of . . . 'enforc[ing] any provision[s]' of ERISA or an ERISA plan." *Mertens v. Hewitt Assocs.*, 508

U.S. 248, 253 (1993) (quoting 29 U.S.C. § 1132(a)(3)). Petitioner attempts to import a substantive limitation on ERISA plans into a statutory provision that deals only with the remedies available to enforce such plans. But "appropriate" modifies "equitable relief," and this Court has interpreted this modifier to refer to the *type of relief* available under a plan, not the *substance of the plan*. *See Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996). And it is not the province of the courts to rewrite the substance of ERISA plans. *See Alessi*, 451 U.S. at 511-14; *Ryan*, 78 F.3d at 126.

It is undisputed that the Plan in this case requires 100 percent recovery of benefits paid on Petitioner's behalf after Petitioner obtained a settlement from a third party, not a "pro rata" recovery or one limited by whether Petitioner was "made whole" by the settlement. And Petitioner has never claimed that the Plan is ambiguous. *See* Pet. App. at 22a. Because there is no ambiguity with respect to the Plan's terms, there is no need to consider whether Petitioner's proposed principles of federal common law such as the "make whole" and "pro rata" doctrines should apply.

Despite the Plan's clear language, Petitioner cites this Court's decision in *Boggs v. Boggs*, 520 U.S. 833 (1997), for the proposition that "the principal purpose of ERISA is 'to protect plan participants and beneficiaries.'" Pet. at 12 (quoting *Boggs*, 520 U.S. at 845). But this purpose of ERISA is in no way undermined by the decisions of the court below and the ten other circuits that have rejected attempts to apply the "make whole" or "pro rata" doctrine to override clear plan language to the contrary. Though individual participants and beneficiaries might gain

if a plan's explicit reimbursement requirements are overridden on an ad hoc basis in their cases, a plan's financial viability would be compromised and the rest of the plan's participants and beneficiaries would suffer if such an approach were adopted. *See Harris*, 208 F.3d at 280-81 ("ERISA objectives could be disserved if the 'make whole' doctrine were to be adopted as the ERISA default rule. Although plan members like the Harrises would benefit financially, ultimately the costs would be borne by all other plan members in the form of higher premiums for coverage."); *see also Cutting*, 993 F.2d at 1298 (Posner, J.). Thus, the Committee's decision to enforce the Plan "protect[s] plan participants and beneficiaries," *Boggs*, 520 U.S. at 845, and fulfills the Committee's fiduciary duty to "preserve assets to satisfy future, as well as present, claims and . . . to take impartial account of the interests of all beneficiaries," *Varity Corp.*, 516 U.S. at 514.

Petitioner cites *Arkansas Department of Health and Human Services, et al. v. Ahlborn*, 547 U.S. 268 (2006), in support of her "pro rata" argument. But *Ahlborn's* holding turned on the particulars of federal Medicaid law and is therefore inapposite. *Ahlborn* involved a state law that required Medicaid recipients to reimburse all payments for medical expenses when they obtain third-party judgments or settlements. *Id.* at 277. This Court held that the state law requirement conflicted with federal Medicaid laws, which entitled a state to only the portion of a judgment or settlement representing payment for medical expenses. *Id.* at 278-80, 292. But ERISA imposes no such substantive rule. To the contrary, ERISA provides no minimum amount of benefits and leaves the substance of an ERISA plan up to the contracting parties. *See Curtiss-Wright*,

514 U.S. at 78 ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits," nor does it "establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans"). In cases where the employee benefit plan in question provides for pro rata reimbursement, *see, e.g.*, *Springs Valley Bank & Trust Co. v. Carpenter*, 885 F. Supp. 1131, 1143 (S.D. Ind. 1993), such reimbursement is appropriate and should be enforced. But the Plan in this case contains no such limitation. The court of appeals thus correctly rejected Petitioner's "pro rata" argument and upheld the Plan's request for full reimbursement.

Because the decision of the Eighth Circuit below is correct on the merits, review by this Court is unnecessary.

III. ENFORCEMENT OF THE PLAN'S TERMS AND REIMBURSEMENT OF THE PLAN WAS JUST AND REASONABLE

Though Petitioner had been a Plan member for just over three months before her accident, the Plan paid a substantial amount—$469,216—to cover her medical expenses without any guarantee that it would be reimbursed. In exchange for this substantial benefit, Petitioner paid premiums and promised that she would reimburse the Plan if she obtained a settlement from a third party. "[I]t would be inequitable to permit [Petitioner] to partake of the benefits of the Plan and then, after [Petitioner] had received a substantial settlement, invoke common law principles to establish a legal justification for [Petitioner's] refusal to satisfy [her] end of the bargain." *Ryan*, 78 F.3d at 127-28. "[T]he

unambiguous language of the Plan obligates [Petitioner] to repay the benefits paid in full . . . , and thus any so-called enrichment is not unjust." *Varco*, 338 F.3d at 692; *see also Cummings v. Briggs & Stratton Ret. Plan*, 797 F.2d 383, 390 (7th Cir. 1986) ("Enrichment is not 'unjust' where it is allowed by the express terms of the . . . plan.").

As the Plan's fiduciary, the Committee had an obligation to all the Plan's participants and beneficiaries to enforce the Plan's terms and preserve its assets. *See Varity Corp.*, 516 U.S. at 514 (An ERISA fiduciary has an obligation "to preserve assets to satisfy future, as well as present, claims" and must "take impartial account of the interests of all beneficiaries"); *see also* RESTATEMENT (THIRD) OF TRUSTS § 79 (2007) (discussing a trustee's duty of impartiality).

Because "self-funded ERISA plans generally have very limited resources that they must use for the benefit of all their participants," "[s]ubrogation is an extremely important tool for maintaining the financial viability of such plans." *Paris v. Iron Workers Trust Fund, Local No. 5 (In re Paris)*, No. 99-1558, 2000 U.S. App. LEXIS 6883, *8-9 (4th Cir. Apr. 17, 2000).[12] To preserve assets for other

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[12] ERISA's goal of minimizing the costs to employers of providing welfare benefits, *see Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997), is also furthered by allowing plans to require full reimbursement. *Cf. United States v. Lorenzetti*, 467 U.S. 167, 177 (1984) (Federal Employees Compensation Act's goal of minimizing costs requires employee who receives workers' compensation benefits to use a third-party recovery to repay the government "regardless of whether the third-party recovery

[Footnote continued on next page]

plan members, ERISA fiduciaries must—and routinely do—enforce reimbursement provisions such as the one at issue in this case. Indeed, the wealth of case law in the circuits came about because ERISA plans took legal action to enforce subrogation provisions when plan participants recovered from third parties, just as the Committee did in this case. *See, e.g.*, *Harris*, 208 F.3d at 276 (ERISA administrator filed a lien against a participant's tort recovery); *United McGill*, 154 F.3d at 170 (plan perfected a lien and then sued for declaratory judgment); *Sunbeam-Oster*, 102 F.3d at 1372 (plan filed a civil complaint against a participant).[13]

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includes compensation for losses other than medical expenses and lost wages").

[13] Full reimbursement is a common practice even in the insurance context, without the primacy ERISA gives to plan language, *Van Orman*, 680 F.2d at 312 ("The Supreme Court has emphasized the primacy of plan provisions . . . ." (citing *Alessi*, 451 U.S. at 511)), and the "make whole" doctrine usually does not apply in the face of clear contract language to the contrary, *see* RUSS ET AL., *supra*, § 223:145; *see also, e.g.*, *Ex parte State Farm Fire & Cas. Co.*, 764 So. 2d 543, 545-46 (Ala. 2000); *Travelers Indem. Co. v. Ingebretsen*, 38 Cal. App. 3d 858, 866 (1974); *Capitol Indem. Corp. v. Strike Zone*, 646 N.E.2d 310, 312 (Ill. App. Ct. 1995); *Willard v. Auto Underwriters, Inc.*, 407 N.E.2d 1192, 1193 (Ind. Ct. App. 1980); *Wine v. Globe Am. Cas. Co.*, 917 S.W.2d 558, 562 (Ky. 1996); *Stancil v. Erie Ins. Co.*, 740 A.2d 46, 46-47 (Md. Spec. Ct. App. 1999); *Westendorf v. Stasson*, 330 N.W.2d 699, 703 (Minn. 1983); *Culver v. Ins. Co. of N. Am.*, 559 A.2d 400, 402 (N.J. 1989); *N. Buckeye Educ. Council Group Health Benefits Plan v. Lawson*, 798 N.E.2d 667, 674 (Ohio Ct. App. 2003); *Ditomasso v. Ocean State Physicians Health Plan, Inc.*, 1988 R.I. Super. LEXIS 52, *5-6 (R.I. Super. Ct. 1988); *Westfield Ins. Co., Inc. v. Rowe*, 631 N.W.2d 175, 180

[Footnote continued on next page]

As the named fiduciary charged with preserving the Plan's assets, the Committee did what was required and, indeed, expected of it under the circumstances. Because full recovery of benefits paid on Petitioner's behalf pursuant to the terms of the Plan was just and reasonable, review of the decision below by this Court is not warranted.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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(S.D. 2001); *Hill v. State Farm Mut. Auto. Ins. Co.*, 765 P.2d 864, 866 (Utah 1988); *Fisher v. Aldi Tire Inc.*, 902 P.2d 166, 168 (Wash. Ct. App. 1995); *Kanawha Valley Radiologists Inc. v. One Valley Bank, N.A.*, 557 S.E.2d 277, 282 (W. Va. 2001).